COMMITTEE REPORT

MR. PRESIDENT:

The Senate Committee on Rules and Legislative Procedure, to which was referred Senate Bill No. 54, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be amended as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning health.

Delete everything after the enacting clause and insert the following:

SECTION 1. IC 4-23-26 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 26. Advisory Committee for Children With Special Health Needs

Sec. 1. As used in this chapter, "committee" refers to the advisory committee for children with special health needs established by section 2 of this chapter.

Sec. 2. The advisory committee for children with special health needs is established.

Sec. 3. The committee consists of the following members:

(1) The director of the children's special health care services program.

(2) The director of the first steps early intervention system.

(3) The chair of the governor's interagency coordinating council for early intervention.

(4) The director of the division of special education created under IC 20-1-6-2.1.

(5) The chair of the children's special health care needs advisory council under 410 IAC 3.2-11.

(6) One (1) representative of the Indiana chapter of the American Academy of Pediatrics.

(7) One (1) representative of a family advocacy group.

(8) Three (3) parents of children with special health needs.

Sec. 4. (a) The governor shall appoint the committee members under section 3(6), 3(7), and 3(8) of this chapter.

(b) The term of each member appointed under subsection (a) is three (3) years.

(c) A committee member identified in subsection (a) may be

reappointed to serve consecutive terms.

Sec. 5. (a) The director of the children's special health care services program is chair of the committee during odd-numbered years.

(b) The director of the first steps program is chair of the committee during even-numbered years.

Sec. 6. The committee shall meet at least quarterly at the call of the chair.

Sec. 7. (a) Six (6) members of the committee constitute a quorum.

(b) The affirmative vote of at least six (6) members of the committee is required for the committee to take any official action.

Sec. 8. (a) Each member of the committee who is not a state employee is entitled to receive both of the following:

(1) The minimum salary per diem provided by IC 4-10-11-2.1(b).

(2) Reimbursement for travel expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency.

(b) Each member of the committee who is a state employee is entitled to reimbursement for travel expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency.

Sec. 9. The committee shall advise and assist the children's health policy board established by IC 4-23-27-2 in the development, coordination, and evaluation of policies that have an impact on children with special health needs by doing the following:

(1) Seeking information from families, service providers, advocacy groups, and health care specialists about state or local policies that impede the provision of quality service.

(2) Taking steps to ensure that relevant health policy issues that have an impact on children with special health needs are forwarded to the children's health policy board.

(3) Advising the children's health policy board with respect to the integration of services across:

(A) programs; and

(B) state agencies;

for children with special health needs.

SECTION 2. IC 4-23-27 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 27. Children's Health Policy Board

Sec. 1. As used in this chapter, "board" refers to the children's health policy board established by section 2 of this chapter.

Sec. 2. The children's health policy board is established to do

the following:

(1) Coordinate programs designed to provide health care to children and their families, including the Medicaid managed care program for children, children with special health care needs, first steps, and the children's health insurance program, in order to achieve a more seamless system that is easy to access for both participants and providers, specifically in the following areas:

(A) Identification of potential enrollees.

(B) Outreach.

(C) Eligibility criteria.

(D) Enrollment.

(E) Benefits and coverage issues.

(F) Provider requirements.

(G) Evaluation.

(H) Procurement policies.

(I) Information technology systems.

(2) Oversee implementation of the children's health insurance program.

(3) Develop a comprehensive policy in the following areas:

(A) Appropriate delivery systems of care.

(B) Enhanced access to care.

(C) The maximum use of funding for various programs.

(D) The maximum provider participation in various programs.

(E) The potential for expanding health insurance coverage to other populations.

(F) Future technology needs.

(G) Appropriate organizational structure to develop health policy in the state.

(4) Collect, analyze, disseminate, and use data when making policy decisions.

Sec. 3. The board consists of the following members:

(1) The secretary of the office of family and social services.

(2) The director of the division of family and children.

(3) The assistant secretary for the office of Medicaid policy and planning.

(4) The state health commissioner.

(5) The commissioner of the department of insurance.

(6) The state superintendent of public instruction.

(7) The budget director.

(8) Two (2) members appointed by the governor, including at least one (1) individual from a family who receives services from the children's health insurance program.

Sec. 4. (a) Five (5) members of the board constitute a quorum.

(b) The affirmative vote of five (5) members of the board is required for the board to take any official action.

Sec. 5. The board shall annually elect a chair from among the members of the board.

Sec. 6. (a) The board shall meet monthly at the call of the

chair.

(b) In addition to the meetings held under subsection (a), the board shall hold public hearings as determined by the chair.

Sec. 7. (a) The term of each member of the board appointed under section 3(8) of this chapter is three (3) years.

(b) A member under subsection (a) may be reappointed to serve consecutive terms.

Sec. 8. (a) Each member of the board who is not a state employee is entitled to receive both of the following:

(1) The minimum salary per diem provided by IC 4-10-11-2.1(b).

(2) Reimbursement for travel expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency.

(b) Each member of the board who is a state employee is entitled to reimbursement for travel expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency.

Sec. 9. (a) The board shall establish objectives for evaluating the children's health insurance program based on health care benchmarks.

(b) The board shall contract with an independent organization to evaluate the children's health insurance program.

(c) An evaluation under subsection (b) must occur one (1) time every two (2) years.

(d) This section does not modify the requirements of other statutes relating to the confidentiality of medical records.

Sec. 10. Based on each evaluation conducted under section 9 of this chapter, the board shall make recommendations to the general assembly for changes in the children's health insurance program.

Sec. 11. The board may draw upon the expertise of other boards, committees, and individuals whenever the board determines that such expertise is needed.

SECTION 3. IC 12-7-2-52.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 52.2. "Crowd out", for purposes of IC 12-17-19, has the meaning set forth in IC 12-17-19-1.**

SECTION 4. IC 12-7-2-91 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 91. "Fund" means the following:

(1) For purposes of IC 12-12-1-9, the fund described in IC 12-12-1-9.

(2) For purposes of IC 12-13-8, the meaning set forth in IC 12-13-8-1.

(3) For purposes of IC 12-15-20, the meaning set forth in

IC 12-15-20-1.

(4) For purposes of IC 12-17-12, the meaning set forth in IC 12-17-12-4.

(5) For purposes of IC 12-17-19, the meaning set forth in IC 12-17-19-2.

~~(5)~~ **(6)** For purposes of IC 12-18-4, the meaning set forth in IC 12-18-4-1.

~~(6)~~ **(7)** For purposes of IC 12-18-5, the meaning set forth in IC 12-18-5-1.

~~(7)~~ **(8)** For purposes of IC 12-19-3, the meaning set forth in IC 12-19-3-1.

~~(8)~~ **(9)** For purposes of IC 12-19-4, the meaning set forth in IC 12-19-4-1.

~~(9)~~ **(10)** For purposes of IC 12-19-7, the meaning set forth in IC 12-19-7-2.

~~(10)~~ **(11)** For purposes of IC 12-23-2, the meaning set forth in IC 12-23-2-1.

~~(11)~~ **(12)** For purposes of IC 12-24-6, the meaning set forth in IC 12-24-6-1.

~~(12)~~ **(13)** For purposes of IC 12-24-14, the meaning set forth in IC 12-24-14-1.

~~(13)~~ **(14)** For purposes of IC 12-30-7, the meaning set forth in IC 12-30-7-3.

SECTION 5. IC 12-7-2-134 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 134. "Office" means the following:

(1) Except as provided in subdivisions (2) and (3), the office of Medicaid policy and planning established by IC 12-8-6-1.

(2) For purposes of IC 12-10-13, the meaning set forth in IC 12-10-13-4.

(3) For purposes of IC ~~12-17-18,~~ **IC 12-17-19,** the meaning set forth in ~~IC 12-17-18-1.~~ **IC 12-17-19-3.**

SECTION 6. IC 12-7-2-135.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 135.8. "Participating plan", for purposes of IC 12-17-19, has the meaning set forth in IC 12-17-19-4.**

SECTION 7. IC 12-7-2-146 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 146. "Program" refers to the following:

(1) For purposes of IC 12-10-7, the adult guardianship services program established by IC 12-10-7-5.

(2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5.

(3) For purposes of IC 12-17-19, the meaning set forth in IC 12-17-19-5.

SECTION 8. IC 12-7-2-149 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 149. "Provider" means the following:

(1) For purposes of IC 12-10-7, the meaning set forth in

IC 12-10-7-3.

(2) For purposes of the following statutes, an individual, a partnership, a corporation, or a governmental entity that is enrolled in the Medicaid program under rules adopted under IC 4-22-2 by the office of Medicaid policy and planning:

(A) IC 12-14-1 through IC 12-14-9.

(B) IC 12-15, except IC 12-15-32, IC 12-15-33, and IC 12-15-34.

(C) IC 12-17-10.

(D) IC 12-17-11.

(3) For purposes of IC 12-17-9, the meaning set forth in IC 12-17-9-2.

(4) For purposes of ~~IC 12-17-18,~~ **IC 12-17-19,** the meaning set forth in ~~IC 12-17-18-2.~~ **IC 12-17-19-6.**

(5) For the purposes of IC 12-17.2, a person who operates a child care center or child care home under IC 12-17.2.

(6) For purposes of IC 12-17.4, a person who operates a child caring institution, foster family home, group home, or child placing agency under IC 12-17.4.

SECTION 9. IC 12-8-1-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 14. The office of the secretary shall improve its system through the use of technology and training of staff to do the following:**

(1) Simplify, streamline, and destigmatize the eligibility and enrollment processes in all health programs serving children.

(2) Ensure an efficient provider payment system.

(3) Improve service to families.

(4) Improve data quality for program assessment and evaluation.

(5) Coordinate payment for and services provided through the children's health insurance program under IC 12-17-19 with:

(A) services provided to children with special health needs; and

(B) public health programs designed to protect all children.

SECTION 10. IC 12-13-8-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. For taxes first due and payable in 1990, each county shall impose a medical assistance property tax levy equal to the amount determined using the following formula:

STEP ONE: Determine the sum of the amounts that were incurred by the county as determined by the state board of accounts for all medical care, including psychiatric care and institutional psychiatric care, for wards of the county office (described in ~~IC 12-15-2-15)~~ **IC 12-15-2-16)** that was provided in 1986, 1987, and 1988.

STEP TWO: Subtract from the amount determined in STEP ONE the sum of:

(A) the amount of bank taxes (IC 6-5-10);

(B) the amount of savings and loan association taxes (IC 6-5-11);

(C) the amount of production credit association taxes (IC 6-5-12); plus

(D) the amount of motor vehicle excise taxes (IC 6-6-5);

that were allocated to the county welfare fund and used to pay for the medical care for wards provided in 1986, 1987, and 1988.

STEP THREE: Divide the amount determined in STEP TWO by three (3).

STEP FOUR: Adjust the amount determined in STEP THREE by the amount determined by the state board of tax commissioners under section 6 of this chapter.

STEP FIVE: Multiply the amount determined in STEP FOUR by the greater of:

(A) the assessed value growth quotient determined under IC 6-1.1-18.5-2 for the county for property taxes first due and payable in 1990; or

(B) the statewide average assessed value growth quotient using the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for property taxes first due and payable in 1990.

STEP SIX: Multiply the amount determined in STEP FIVE by the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this section will be first due and payable.

SECTION 11. IC 12-15-2-14 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 14. (a) An individual:

(1) who is less than ~~one (1) year~~ **nineteen (19) years** of age;

(2) who is not described in 42 U.S.C. 1396a(a)(10)(A)(i); and

(3) whose family income does not exceed the income level established in subsection (b);

is eligible to receive Medicaid.

(b) An individual described in this section is eligible to receive Medicaid, subject to 42 U.S.C. 1396a et seq., if the individual's family income does not exceed one hundred fifty percent (150%) of the federal income poverty level for the same size family.

(c) The office may apply a resource standard in determining the eligibility of an individual described in this section.

SECTION 12. IC 12-15-2-15.7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 15.7. ~~(a)~~ An individual who is less than nineteen (19) years of age and who is eligible for Medicaid under ~~sections~~ **section** 14 ~~through 15.6~~ of this chapter is eligible to receive Medicaid until the earlier of the following:

(1) The end of a period of twelve (12) consecutive months following a determination of the individual's eligibility for Medicaid.

(2) The individual becomes nineteen (19) years of age.

~~(b) This section expires August 31, 1999.~~

SECTION 13. IC 12-15-2.2-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. A qualified entity may establish the presumptive eligibility of an individual who may be eligible for:

(1) Medicaid under IC 12-15-2-11 through ~~IC 12-15-2-15.6;~~ **IC 12-15-2-14;** or

(2) services from the children's health insurance program under ~~IC 16-35-6.~~ **IC 12-17-19.**

SECTION 14. IC 12-15-2.2-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. The office shall provide each qualified entity with the following:

(1) Application forms for:

(A) Medicaid; and

(B) the children's health insurance program under ~~IC 16-35-6.~~ **IC 12-17-19.**

(2) Information on how to assist pregnant women, parents, guardians, and other individuals in completing and filing the application forms.

SECTION 15. IC 12-15-4-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5. (a) The office shall implement outreach strategies that build on community resources.**

(b) Schools must be included in all outreach strategies implemented under subsection (a).

SECTION 16. IC 12-15-12-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 13. For a managed care program established or authorized by the office, or established or authorized by another entity or agency working in conjunction with or under agreement with the office, the office shall:**

(1) administer the managed care program on a community level to the greatest extent possible; and

(2) offer to contract with, and encourage contracts from, community entities, including private entities, to manage any of the following:

(A) Outreach for and enrollment in the managed care program.

(B) Provision of services.

(C) Consumer education and public health education.

(D) Day to day administration of the managed care program.

SECTION 17. IC 12-15-20-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. The Medicaid indigent care trust fund is established to pay the state's share of the following:

(1) Enhanced disproportionate share payments to providers under IC 12-15-19.

(2) Disproportionate share payments and significant disproportionate share payments for certain outpatient services

under IC 12-15-17-3.

(3) Medicaid payments for pregnant women described in IC 12-15-2-13 and infants and children described in IC 12-15-2-14. ~~IC 12-15-2-15, and IC 12-15-2-15.5.~~

(4) Municipal disproportionate share payments to providers under IC 12-15-19-8.

SECTION 18. IC 12-17-19 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2000]:

Chapter 19. Children's Health Insurance Program

Sec. 1. As used in this chapter, "crowd out" means the shift of certain individuals from private insurance coverage to insurance coverage provided by the program due to direct or indirect incentives furnished to the individuals by a private insurance provider.

Sec. 2. As used in this chapter, "fund" refers to the children's health insurance program fund established by section 17 of this chapter.

Sec. 3. As used in this chapter, "office" refers to the office of the children's health insurance program established within the office of the secretary under section 7 of this chapter.

Sec. 4. As used in this chapter, "participating plan" means:

(1) a provider network plan established by the office to provide health care services; or

(2) an insurance plan purchased by the state to provide health care services.

Sec. 5. As used in this chapter, "program" refers to the children's health insurance program established by section 7 of this chapter.

Sec. 6. (a) As used in this chapter, "provider" means a person that provides health insurance in Indiana.

(b) Except as provided in subsection (c), the term includes the following:

(1) A licensed insurance company.

(2) A health maintenance organization.

(3) A multiple employer welfare arrangement.

(4) A person providing a plan of health insurance subject to state insurance law.

(c) For purposes of section 10(b) of this chapter, the term includes a limited service health maintenance organization (as defined in IC 27-13-34-4) and a preferred provider plan (as defined in IC 27-8-11-1).

Sec. 7. The office of the children's health insurance program and the children's health insurance program are established within the office of the secretary.

Sec. 8. A child may apply at:

(1) an enrollment center as provided in IC 12-15-4-1; or

(2) the office of a qualified entity under IC 12-15-2.2;

to receive health care services if the child meets the qualifications described in section 18 of this chapter.

Sec. 9. (a) The office shall design and administer a system to obtain health services for eligible children.

(b) The office shall not use the same eligibility determination, enrollment, and claims payment systems as are used by the Medicaid managed care program for children.

Sec. 10. (a) The office may contract with providers under IC 5-22 to arrange to provide health insurance or health services to a child who is enrolled in the program. A contract under this subsection must require a provider to do the following:

(1) Serve as a qualified entity (as defined in IC 12-15-2.2-1) in order to determine the presumptive eligibility for pregnant women and children for Medicaid as provided in IC 12-15-2.2.

(2) Assist a presumptively eligible individual under subdivision (1) to select a primary care provider.

(3) Establish locations where an applicant may apply to receive services provided by the program.

(4) Provide education concerning the following:

(A) The responsible use of health facilities and information.

(B) Preventive care.

(C) Parental responsibilities for a child's health care.

(5) Provide outreach and evaluation activities for the program.

(b) The office may contract with providers to arrange to provide the services described in section 26(b) of this chapter. A provider under this subsection must:

(1) be eligible to receive reimbursement from the office; and

(2) comply with subsection (a)(3), (a)(4), and (a)(5).

Sec. 11. (a) The office shall establish performance criteria and evaluation measures for a provider entering into a contract under section 10 of this chapter.

(b) The office shall assess monetary penalties against a provider that fails to comply with the requirements of this chapter or a rule adopted under this chapter.

Sec. 12. (a) A provider (as defined in IC 12-7-2-149(2)) that participates in the Medicaid program as provided in IC 12-15-11 is considered a provider for purposes of the program.

(b) A provider for the program is considered a provider in the Medicaid program under IC 12-15.

Sec. 13. (a) The office shall incorporate creative methods, reflective of community level objectives and input, to do the following:

(1) Encourage beneficial and appropriate use of health care services.

(2) Pursue efforts to enhance provider availability.

(b) In determining the best approach for each area, the office shall, in collaboration with communities, do the following:

(1) Evaluate distinct market areas.

(2) Weigh the advantages and disadvantages of alternative

delivery models including the following:

(A) Risk-based managed care only.

(B) Primary care gatekeeper model only.

(C) A combination of clauses (A) and (B).

Sec. 14. (a) The office shall offer to contract with, and shall encourage contracts from, community entities, including private entities, to manage any of the following:

(1) Outreach for and enrollment in the program.

(2) Provision of health care services.

(3) Consumer education and public health education.

(4) Day to day administration of the program.

(b) The office shall administer the program on a community level to the greatest extent possible.

Sec. 15. The office shall adopt a sliding scale formula that:

(1) specifies the premiums, if any, to be paid by the parent or guardian of a child enrolled in the program; and

(2) is based on the child's family income.

Sec. 16. (a) The office shall annually adjust participation requirements to reflect the amount of money available to obtain health services for children enrolled in the program.

(b) The office shall use only the funds appropriated to the office to operate the program.

Sec. 17. (a) The children's health insurance program fund is established. The purpose of the fund is to pay all expenses relating to:

(1) the program; and

(2) children who are eligible for:

(A) Medicaid under IC 12-15-2-14; and

(B) reimbursement under Title XXI of the federal Social Security Act.

(b) The office shall administer the fund.

(c) The fund consists of the following:

(1) Amounts appropriated by the general assembly.

(2) Amounts appropriated by the federal government.

(3) Fees, charges, gifts, grants, donations, money received from any other source, and other income funds as may become available.

(d) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested.

Sec. 18. (a) In order to enroll in the program, a child must meet the following requirements:

(1) The child and the child's family may not have access to affordable health insurance through an employer.

(2) The child's family agrees to provide copayments for services based on a sliding fee scale developed by the office.

(3) The child is less than nineteen (19) years of age.

(4) The child is a member of a family with an annual income of:

(A) more than one hundred fifty percent (150%); and

(B) not more than two hundred percent (200%);

of the federal income poverty level.

(5) The child is a resident of Indiana.

(6) The child meets all eligibility requirements under Title XXI of the federal Social Security Act.

(7) Except as provided in subsection (b), the child must be uninsured for at least three (3) months.

(b) The following are exempted from the requirement under subsection (a)(7):

(1) A child who is a member of the high risk pool and who has ongoing medical needs.

(2) A child who loses coverage through the termination of a parent's employer plan.

(3) A child whose parents have lost jobs with insurance coverage.

(4) A child who loses insurance coverage due to the divorce of the child's parents.

(c) The office may adjust eligibility requirements based on available program resources under rules adopted under IC 4-22-2.

Sec. 19. (a) Subject to subsection (b), a child who is eligible for the program shall receive services from the program until the earlier of the following:

(1) The end of a period of twelve (12) consecutive months following the determination of the child's eligibility for the program.

(2) The child becomes nineteen (19) years of age.

(b) Subsection (a) applies only if the child and the child's family comply with all enrollment requirements.

Sec. 20. (a) The office shall implement outreach strategies that build on community resources.

(b) Schools shall be included in all outreach strategies implemented under subsection (a).

Sec. 21. To be eligible to receive reimbursement from the office, a provider shall offer health care services required by this chapter to an eligible child without:

(1) regard to the child's health status; and

(2) imposing a preexisting condition exclusion;

except that a preexisting condition exclusion may be applied if health care services are provided through a group health plan or group health insurance coverage, consistent with the limitations on imposing preexisting condition exclusions provided in state and federal law.

Sec. 22. Premium and cost sharing amounts established by the office are limited as follows:

(1) Deductibles, coinsurance, or other cost sharing are not permitted with respect to benefits for well-baby and well-child care, including age appropriate immunizations.

(2) Premiums, deductibles, and other cost sharing may be imposed on a sliding scale related to family income. However, the total annual aggregate cost sharing with

respect to all children in a family under this chapter may not exceed five percent (5%) of the family's income for the year.

Sec. 23. Providers shall use existing health insurance sales and marketing methods, including the use of agents and payment of commissions, to do the following:

(1) Inform families of the availability of the program.

(2) Assist families in obtaining health insurance and health services for children under the program.

Sec. 24. A child who is eligible to participate in the program is eligible for coverage with a participating plan regardless of the child's health status.

Sec. 25. (a) A child who is participating in the program may change between participating plans only during an annual coverage renewal period, unless the child moves outside of the geographic service area of the participating plan in which the child is enrolled.

(b) A child who moves to an area outside the geographic service area of the participating plan in which the child is enrolled shall provide notice to the participating plan at least five (5) days before the child may change participating plans.

Sec. 26. (a) The office shall offer health insurance coverage for the following basic services:

(1) Inpatient and outpatient hospital services.

(2) Physicians' services (as defined in 42 U.S.C. 1395x(q)) provided by a physician (as defined in 42 U.S.C. 1395x(r)).

(3) Laboratory and x-ray services.

(4) Well-baby and well-child care, including:

(A) age appropriate immunizations; and

(B) services provided under the early and periodic screening, diagnosis, and treatment program (EPSDT) under IC 12-15.

The office may offer services in addition to those listed in this subsection as long as appropriations to the program exist to pay for the additional services.

(b) The office shall offer health insurance coverage for the following additional services if the coverage for the services has an actuarial value equal to the actuarial value of the services provided by the benchmark program determined by the children's health policy board established by IC 4-23-27-2 for the following:

(1) Prescription drugs.

(2) Mental health services.

(3) Vision services.

(4) Hearing services.

(5) Dental services.

(c) Notwithstanding subsection (b), the office may not impose treatment limitations or financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses.

(d) The children's health policy board established by

IC 4-23-27-2 shall annually:

(1) review the benefits provided to program enrollees; and

(2) adjust the benefits as needed to remain within the program's appropriations.

Sec. 27. The office shall do the following:

(1) Establish a penalty to be paid by the following:

(A) An insurer, insurance agent, or insurance broker, for knowingly or intentionally referring an insured or the dependent of an insured to the program in order to receive health care when the insured receives health insurance through an employer's health care plan that is underwritten by the insurer.

(B) An employer, for knowingly or intentionally referring an employee or the dependent of an employee to the program in order to receive health care when the employee receives health insurance through the employer's health care plan.

(C) An employer that knowingly or intentionally changes the terms of coverage for or premiums paid by an employee in order to force an employee or the dependent of an employee to apply to the program in order to receive health care.

(2) Create standards to minimize the incentive for:

(A) an employer to eliminate or reduce health care coverage for an employee's dependents; or

(B) an individual to eliminate or reduce health care coverage for a dependent of the individual.

Sec. 28. Reviews and evaluations of the program shall:

(1) be conducted in compliance with federal requirements; and

(2) include an analysis of the extent to which crowd out is occurring.

Sec. 29. The office shall employ electronic claim administration, payment, and data collection systems that do the following:

(1) Immediately advise a provider's office of any error in a claim submitted by the provider by type of error and line number of the error, to allow a claim error to be corrected immediately. The claim may then be immediately repriced, adjudicated, and an explanation of benefits printed out before the child leaves the provider's office.

(2) Increase the quality of care by increasing early and periodic screening, diagnosis, and treatment program (EPSDT) compliance rates for immunization and other wellness and preventative medical procedures.

(3) Increase the child's and parent's or guardian's role in the care of the child.

(4) Provide claim related data available to the provider and the office in a manner that allows immediate analysis and reports created on the types and number of procedures

performed throughout the state on the same day.

(5) Increase the convenience and decrease the administrative related tasks for both the child's family and the provider.

(6) Insure the privacy and security of claim information.

(7) Reduce fraud.

(8) Standardize and simplify electronic claims and data consistent with:

(A) regulations issued by the Health Care Financing Administration; and

(B) the Health Insurance Portability and Accountability Act.

Sec. 30. (a) In order to comply with section 29 of this chapter, the office shall:

(1) contract with a provider of electronic claim administration, payment, and data collection systems; or

(2) provide the services;

that meet the requirements of subsections (b) through (g).

(b) To increase the quality of care for children enrolled in the program by increasing early and periodic screening, diagnosis, and treatment program (EPSDT) compliance rates for immunization and other wellness and preventative medical procedures, the office shall provide to the child's family at the point of service the status of the child's:

(1) scheduled immunizations;

(2) preventative medicine;

(3) wellness procedures; and

(4) any other EPSDT or related information;

to remind providers and the child's family to schedule specific visits and procedures.

(c) To provide claim related data to the provider and the program, the office shall:

(1) allow the provider to retain, manipulate and produce reports from claims regarding the nature and number of procedures performed;

(2) manipulate claim data to allow immediate analysis and daily reporting on the types and number of procedures performed throughout the state, in order to correlate and amend plan benefits to match the health needs of the children enrolled in the program; and

(3) allow the child's parent or guardian to review and approve a claim by entering a personal identification number to certify that the procedures listed on the claim were received by the child.

(d) To increase the convenience and decrease the administrative related tasks for both the child's family and the provider, the office shall do the following:

(1) Calculate any copayment due by the child's family at the point of service.

(2) Make available the amount paid towards the deductible to date by the child's family at the point of service.

(3) Calculate the exact amount that will be paid to the provider, and pay the provider that amount via wire transfer at a date of the office's choosing.

(4) Allow a claim with an error to be repriced and adjudicated by instructing the provider's staff of the type, and line number of any claim error immediately, only after the claim can be accepted.

(e) To insure the privacy and security of claim information, the office shall transmit claims in a manner that is consistent with the Health Care Financing Administration's rules on data security, so that:

(1) each transmission is adequately encrypted; and

(2) authentication or identification of communication partners occurs within effective password or key management systems.

(f) To reduce fraud, the office shall do the following:

(1) Immediately check a child's eligibility to receive services from the program.

(2) Immediately determine if a claim is a duplicate claim submission.

(3) Immediately determine if duplicate procedures, using slightly differently codes, are part of the same claim.

(4) Immediately determine if a point of service and a procedure code combination is valid.

(5) Immediately determine if the:

(A) same procedure was performed for the child on the same day; and

(B) combination of procedures on the claim can be performed on the same day.

(6) Immediately determine if a provider is identified as a provider whose claims need to be reviewed.

(7) Immediately determine if claims with specific procedures, performed by specific providers, need to be reviewed.

(8) Insure that only authorized providers may access the encounter and claim transmission network.

(g) To standardize and unify the electronic claim data for the office, the office shall comply with:

(1) Health Insurance Portability and Accountability Act Administrative Simplification requirements; and

(2) corresponding regulations issued by the Health Care Finance Administration;

to insure uniform data and systems between Medicaid and the program.

Sec. 31. Not later than April 1, the office shall provide a report describing the program's activities during the preceding calendar year to the:

(1) budget committee;

(2) legislative council; and

(3) children's health policy board established by IC 4-23-27-2.

Sec. 32. (a) The office shall adopt rules under IC 4-22-2 to implement this chapter.

(b) The rules adopted under subsection (a) must include rules for determining additional methods for complying with federal requirements relating to crowd out.

SECTION 19. THE FOLLOWING ARE REPEALED [EFFECTIVE UPON PASSAGE]: IC 12-7-2-139.1; IC 12-15-2.2-12; IC 12-17-18.

SECTION 20. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 1999]: IC 12-15-2-15; IC 12-15-2-15.5.

SECTION 21. [EFFECTIVE UPON PASSAGE] **(a) Notwithstanding IC 12-17-19, as added by this act, the children's health insurance program shall begin operations not later than January 1, 2000.**

(b) This SECTION expires January 1, 2001.

SECTION 22. [EFFECTIVE UPON PASSAGE] **(a) Notwithstanding IC 4-23-27-9, as added by this act, the first evaluation of the children's health insurance program under IC 12-17-19 must be completed before July 1, 2001.**

(b) This SECTION expires July 1, 2002.

SECTION 23. **An emergency is declared for this act.**

(Reference is to SB 54 as introduced.)

and when so amended that said bill be reassigned to the Senate Committee on Health and Provider Services.

GARTON Chairperson